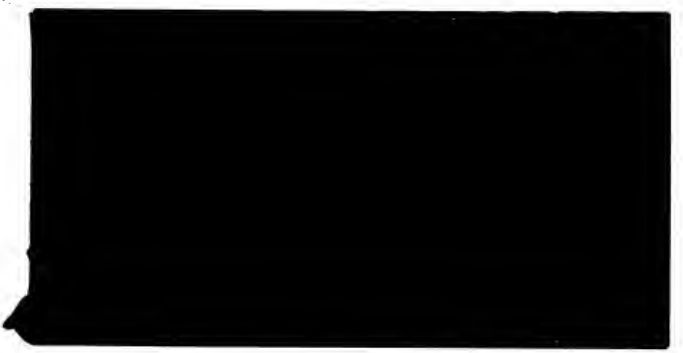
INSURED EMPLOYEE BENEFIT PLAN REVIEW AND AUDIT

State of Montana

January, 1982

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MONTANA
STATE CAPITOL • HELENA



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Office of the Legislative Auditor

STATE CAPITOL
HELENA, MONTANA 59620
406/449-3122

JAMES H. GILLETT, C.P.A.
ACTING LEGISLATIVE AUDITOR

JOHN W. NORTHEY
STAFF LEGAL COUNSEL

January 13, 1982

The Legislative Audit Committee
of the Montana State Legislature:

Transmitted herewith is the report on the audit of selected aspects of the Department of Administration State Employees Benefit Plans.

The audit was conducted by Peat, Marwick, Mitchell & Co., CPAs, under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

Written responses to the report are included in the back of the audit report.

Respectfully submitted,

James H. Gillett

James H. Gillett, CPA
Acting Legislative Auditor

Peat, Marwick, Mitchell & Co.

Certified Public Accountants

2000 Commerce Tower
P.O. Box 13127
Kansas City, MO 64199

January 27, 1982

Mr. James H. Gillett, C.P.A.
Acting Legislative Auditor
State of Montana
State Capitol
Helena, Montana 59601

Dear Mr. Gillett:

We have completed our review and audit services for the State of Montana's insured employee benefit plans and are pleased to present our report. It is organized as follows:

- Introduction
- Results: State Administration
- Results: Blue Cross Plan
- Conclusions and Recommendations: State Administration
- Conclusions and Recommendations: Blue Cross

A brief summary of each of these sections is included in this letter.

SUMMARY OF RESULTS

Our findings with regard to claims and other administrative functions performed by the State and Blue Cross are presented below.

State Administration

Based on our analysis of the State Administration we find that:

- The State has a brief administration manual describing agency level administrative procedures. The manual does not describe the administrative activity as clearly or completely as manuals in use by other employers with which we are familiar. (Subsequent to our field work at the Department of Administration, a revised manual has been prepared.)

- The State does not have a written set of administrative instructions describing the Department of Administration's (Department) administrative activity for the plans.

- Agency Personnel Clerks responsible for plan administration generally exhibited a good understanding of the administrative activity and perform their duties properly. Logistical difficulties and a lack of complete understanding of some activities have caused delays and errors.

- Department administration requires a substantial amount of manual activity and error correction. While the premium collection and reporting process involves the use of the State's computerized payroll system, computer program limitations result in a significant amount of clerical work to produce an accurate premium report.

- Procedures regarding self-payment of premium and coverage termination dates cause confusion and add to the plan's administrative complexity.

- In general, the administrative procedures conform to the insurance company contractual requirements. Areas where improvement in contractual compliance could be made include:

  - Periodic employee eligibility verification,

  - Life insurance premium collection and reporting, and

  - Life insurance waiver of premium claim procedures.

Blue Cross Plan

Based on our analysis of data gathered regarding the Blue Cross of Montana (BC) claim administration services, we find that:

- The claims administration system (manual system) used for the 1980-1981 plan year remained generally unchanged from the system used in the prior year. We observed improvements in BC's cost containment activity.

- Observed medical claim payment errors occurred in 6 percent of the claims in our audit sample.

- Net overpayments were 1.3 percent of the dollar payments in our audit sample.

- Nearly 77 percent of the claims reviewed for turnaround time were paid within 14 days of receipt or properly documented for cause of delay.

- Many of the claims reviewed were submitted without including proper identification information.

- The computerized dental claim system currently in use was not programmed properly based on the State's plan provisions. (We have been advised by BC that the programming is now corrected.)

- Employees over age 65 may elect not to pay Medicare Part B premium and receive BC benefits for Part B type services on the same basis as employees under age 65.

CONCLUSIONS AND RECOMMENDATIONS

The major conclusions and recommendations contained in our report are summarized below.

State Administration

Our major conclusions and recommendations regarding the State Administration of the plans include:

- The administration manual we reviewed did not provide an appropriate level of instructions for agency Payroll Clerks. During a meeting with Department personnel, we recommended the manual be rewritten. (A revised manual has now been prepared.)

- We further recommended a manual be prepared to describe Department administrative activity. We understand plans have been made to prepare a Department manual.

- Agency Payroll Clerk training should be upgraded and the Department should request cooperation of other agency personnel to insure proper information flow for plan administration.

- The present payroll system could be modified to automatically make benefit and premium increases caused by salary and age changes. This modification would reduce the clerical time involved in the premium and collection process. We recommend the system modifications be made to reduce clerical time in this process.

- The collection and reporting of premium for employees who self-pay their premium (e.g. employees on leave of absence) involved a substantial amount of clerical time. Use of data or word processing equipment with basic memory and totalling capabilities plus improved payroll clerk training would reduce the Department's clerical involvement. We further recommend such equipment be used for this activity and payroll clerk receive additional instruction.

. Administrative compliance with insurance contract provisions appears to be appropriate in most respects. We recommend the following changes be made to improve the compliance:

  - Self-pay premium and requests for premium refunds for terminated employees should be received by the Department by the first of the month.

  - Payroll Clerks should review pre-payroll lists monthly to verify eligibility for each participant and to check the status of previously ineligible employees.

  Our recommendation regarding payroll system changes, if implemented, should improve contractual compliance with respect to premium payment.

Blue Cross Plan

Our major conclusions and recommendations regarding the BC claims administration include:

. The observed claim payment error frequency is similar to the error frequency observed by PMM&Co. in similar engagements.

. The observed net overpayment error rate is .7 to .3 percentage points above the error rate generally observed by PMM&Co. in similar engagements.

. BC is using a new computerized claim payment system to process claims during the 1981-1982 plan year. BC advised us that many of the payment errors observed during this engagement would not occur under the new system.

. We recommend the claim payment activity be audited during the current year and/or at the end of the current year to determine the degree of improvement in error frequency and rate resulting from the new system. We further recommend the audit be conducted under the same conditions as existed for the claim audit portion of our services this year so as to permit comparison with error data presented in this report.

. Claim turnaround time is not as rapid as the turnaround time observed in similar PMM&Co. engagements. Some of this delay is caused by participants filing claim information with incomplete data. We recommend the State and BC take the following action to improve claim turnaround time:

  - Provide claim filing instructions to employees.

  - Agree on a turnaround time goal such as 85 percent of claims paid within two weeks (or proper documentation for delay).

  - Establish a monitoring and feedback system to determine the degree of turnaround time improvement.

- Based on our review and subsequent assurance that the dental plan claim system has been modified to conform to plan specifications, we conclude the BC dental claim system should be effective in accurately processing the State employee's dental claims.

- We recommend the State audit dental plan claims processed during the first six months of the present plan year to verify that the system is performing properly.

- The present practice of permitting employees who are over age 65 to elect not to participate in Medicare Part B when first eligible may result in a delay in their coverage effective date when they actually retire. We recommend the State pay the Part B premium for employees over age 65 and negotiate a similar premium reduction from BC.

- Our review services performed in 1980 contained a number of recommendations. Based on our interview process, we conclude the State has reviewed and implemented several of those recommendations. We suggest the State and BC jointly review the remaining recommendations resulting from last year's review and work toward implementation as deemed appropriate.

STATE AND BC RESPONSES

Drafts of our report were provided to the Department of Administration and BC for their comment. Copies of their written comments are attached as Exhibits C and D to the report.

* * * * *

We appreciate the opportunity to be of service to the State of Montana in this most important program.

Yours truly,

Peat, Marwick, Mitchell & Co.

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I-INTRODUCTION

The State of Montana (State) provides health care and dental care insurance as part of an overall employee benefit program for State employees including elected officials, certain retired employees and their dependents. The State pays the premium for active employees and a portion of the premium for dependent coverage. The State does not contribute toward the premium for employees on leave of absence. Approximately 10,000 employees are participating in the insurance programs. About 50 percent of the employees have elected to insure their dependents.

Blue Cross of Montana (BC) was selected to provide the health care insurance for all employees and dependents effective September 1, 1979. As of that date, Aetna Life and Casualty (Aetna) was selected to provide the dental care insurance along with life and accidental death and dismemberment insurance.

Both BC and Aetna initially issued their master contracts with renewal dates of September 1, 1980. By mutual agreement with the State, these master contracts were renewed as of August 1, 1980.

Based on the results of a competitive bidding process, BC was awarded the health care and dental care insurance as of August 1, 1981.

PURPOSE OF SERVICE

Section 2-18-816, MCA (Montana State Law) requires the State Legislative Auditor or an independent certified public accountant to perform an annual audit of the State employee group benefit plans. Peat, Marwick, Mitchell & Co. (PMM&Co.) was selected to perform audit and review services for the BC plan and the State's internal plan administration pursuant to an Audit Contract dated September 28, 1981. The purpose of the services was to comply with Section 2-18-816, MCA.

SCOPE OF SERVICE

The scope of our service was stated in our proposal letter dated August 20, 1981 to Mr. James H. Gillett, C.P.A., acting Legislative Auditor. The scope included:

- A review and audit of the current State administration practices for the Health, Dental and Life Insurance Plans (the Life Insurance Plan is currently provided by Northwestern National Life Insurance Company (NWNL);
- A review and audit of the BC adjudication of Health Care Plan claims during the 1980-1981 plan year; and
- A review of the BC administration and adjudication process for the Dental Care Plan for the 1981-1982 plan year.

The scope of our services did not extend to the 1980-1981 plan years for the Aetna Dental Care and Life Insurance Plans. These plans were terminated by the State as of July 31, 1981. Incurred claims for these two plans exceeded premium during the contract period, based on information provided to us by the State.

State Administration

Our Services regarding a review of the State's administration of the insured employee benefit plans included:

- A review of present procedures to determine the extent and completeness of written instructions regarding each phase of the internal administration.
- An administrative audit of selected transactions and observation of administrative activity to determine the extent of compliance with written procedures and the complexity of the work flow.
- A review of contractual compliance to determine the extent of compliance with insurance company contractual provisions and requirements in the Administration Manual.

Health Care Plan

Our services for the Health Care Plan were similar to the services PMM&Co. provided last year except for the claim selection method. Last year, claims were selected judgementally. This year, claims were randomly selected so as to permit observations regarding the entire claim population and comparisons to other claim processing systems as well as the BC system in future years.

Dental Care Plan

As of August 1, 1981, BC provides the Dental Care Plan benefits. BC recently converted to a new computerized claim processing system. The State's Dental Care Plan is not a standard BC dental plan and certain computer program and administrative procedure changes were required to accommodate the State's plan.

Our services for the Dental Care Plan involved a review of the claim processing system to determine if the BC dental claim system has been developed to appropriately adjudicate claims under the State's plan.

II-RESULTS: STATE ADMINISTRATION

The review and evaluation of the State's administration of the insured employee benefit plans involved interviews with Employee Benefits Bureau personnel, interviews with Payroll Clerks at four State Agencies or Departments and a review and analysis of work flow regarding plan administration. In addition, we reviewed the insurance contracts issued by BC and NWNL to identify State administrative requirements imposed by the contracts.

The results of our review and analysis are presented below.

WRITTEN ADMINISTRATIVE INSTRUCTIONS

Instructions for administration of the insured employee benefit plans are contained in the State Administration Manual prepared by the Employee Benefits Bureau. The Manual addresses various aspects of plan administration and was intended to provide guidance to Payroll Clerks who have the responsibility for much of the day-to-day enrollment, status change, and premium collection activities for the plans.

The Manual defines terms and provides general instructions for adminstration. Due to the complexity of the administration routine and the fact that Payroll Clerks have duties other than plan administration, we believe the Manual is not detailed enough to provide meaningful assistance in all aspects of administration.

Sections of the Administration Manual which we believe could be described in more detail so as to improve the administrative activity are:

- Eligible Employees, Section 4.02. This Section defines employees eligible for participation in the plans. As we understand it, this definition has been taken from State law. However, the definition of eligible employees is not consistent among the branches of government and may produce confusion for Payroll Clerks.

- Employees on Workers' Compensation, Section 4.07. This Section states that such employees must self-pay the premium for coverage. In actual practice, some agencies permit State funds to be used for such premium. Instructions should be included to describe the procedures under both approaches.

- Distribution of Completed Enrollment Forms, Section 5.02. This Section describes forms distribution. However, instructions regarding completion of forms, including payroll status forms, appear to be insufficient to avoid errors.

- Evidence of Insurability, Section 5.03. This Section does not adequately describe the steps involved in providing evidence of insurability to BC or NWNL.

- Effective Date of Insurance, Section 5.06. This Section addresses the date insurance becomes effective. Section 7.00 addresses termination of insurance. Based on our review of the State administration and our audit at BC, these two Sections appear to be causing administrative difficulty. Again, specific instructions appear to be insufficient to avoid errors.

- Self-Pay, Section 6.01. The instructions for self-pay of medical and life coverage do not appear to be specific enough to avoid late payments by individuals who self-pay their premium. Specific instructions and a statement regarding coverage cancellation may reduce the additional effort involved in collecting individual premium payments and reinstating coverage.

- Employee Benefits Bureau Activity. The activities of the Bureau are not described in the Manual. While personnel generally appear to perform properly, written instructions would provide a degree of insurance in the event of leave of absence or turnover of key administrative employees.

In addition to the above, the Manual does not describe procedures to periodically review the eligibility of employees and dependents based on the definitions for eligible employees and dependents.

AGENCY LEVEL ADMINISTRATION

The Payroll Clerk is responsible for initiating most of the administrative activity. Based on our interview and review activity, we conclude the Payroll Clerks in most agencies and departments are administering the plans in conformance with the Administration Manual.

We conducted an interview and reviewed personnel records at Fish, Wildlife and Parks. In general, this agency is administering the plans in conformance with the Manual. However, they are experiencing time delay and accuracy problems regarding enrollment of new employees and status changes. Based on our analysis, we believe the time delays and accuracy problems are caused by:

- The size of the agency and the fact that employees are located throughout the State rather than just in Helena;

- Failure to inform the Payroll Clerk of status changes, including changes to leave of absence status; and

- A generally lower degree of understanding, compared to other agencies reviewed, of the administrative routine.

Based upon discussions with Ms. Loughrie, Administrative Assistant, Employee Benefits Bureau; many of the errors and delays are caused by agency Payroll Clerks who have not gained a complete understanding of the administrative routine.

EMPLOYEE BENEFITS BUREAU (EBB) ADMINISTRATION

Ms. Loughrie is responsible for performing and/or coordinating the major portion of the EBB administration of the plans. As indicated above, her activities are not described in the Manual. Based on our interviews with Ms. Loughrie plus a review of administrative records and routines, we make the following observations:

Waiver of Premium

Employees who become disabled may be eligible to file a waiver of premium claim under the life insurance plan. Ms. Loughrie assists in filing these claims, but (under the present system) may not be advised of all eligible employees as she is not informed by the individual agencies of employees on medical leave of absence.

Premium Statement Preparation

The preparation of monthly premium statements for BC and NWNL involves obtaining a count of participants and premium from:

- Central Payroll,
- PERS (Retired Employees),
- Self-Pay Participants, and
- Legislative Participants.

The participant data and premium must be reconciled based on previous month's data, new entrants, terminations and status changes. This process is time consuming due to the computerized payroll system limitations and the volume of incorrect entries on the payroll system. The payroll system is the basic recordkeeping and premium collection tool.

The following events produce changes in premium and presently require input from Payroll Clerks or EBB to produce changes on the payroll system:

- New plan participant. Based on the employee's employment date and coverage effective date, a one-time premium deduction followed by normal bi-weekly deductions may be required. Under the present system, separate data inputs are required.
- Changes in coverage. Changes, including automatic increases in life insurance resulting from salary increases, require a manual entry to change the monthly premium.
- Age changes. The life insurance premium varies by age. As an employee advances into new age brackets, the premium for that employee increases. Under the present payroll premium collection system, a change form must be prepared to increase the premium collected.

. Coverage termination or change to self-pay status. Separate, manual change entries are required in these events based on the effective date of termination or changes in status.

Based on our review, we believe the payroll system contains an effective edit process to identify incorrect entries and the need to make changes in premium due to various status and benefit changes. However, the payroll system is not properly programmed to make changes without manual input. This requires substantial manual activity taking personnel time that could be utilized in other areas of administration and resulting in incorrect premium payment.

Premium Refund Activity

Based on our review of the premium refund activity, a worksheet is prepared to calculate refunds due from BC (resulting from incorrectly paid premium in previous months) and amounts due employees and former employees. Following the preparation of the worksheet, separate lists are prepared to request refunds from BC and payment requests for Central Services (refunds to employees).

Preparation of the lists appears to be duplicative effort as all appropriate data is available on the worksheet.

The premium refund activity includes a request to Central Services by Ms. Loughrie. Once prepared, the employee's refund check is given to Ms. Loughrie who sends it on to the employees agency Payroll Clerk.

This process appears to be inefficient and perhaps not consistent with proper internal control procedures.

Collection of Self-Pay Premium

The premium collection activity at EBB requires approximately four and one-half days per month to complete, based on our review. The activity involves a review of data from Payroll Clerks, preparation of worksheets, tabulation of premium and preparation of a listing of self-pay participants for premium payment purposes.

This process appears to be unnecessarily extended and tedious due to a lack of basic word or data processing equipment for storage of prior month data.

Communication

Various EBB employees are involved with verbal and written communication with BC, NWNL and employees. Ms. Loughrie has primary contact responsibility for areas relating to the day-to-day administration of the plan and has frequent verbal contact with employees regarding coverage. All communication activities are coordinated by Dave Evenson, Chief, EBB.

ADMINISTRATIVE COMPLIANCE WITH INSURANCE CONTRACTS

Proper administration of insured employee benefit plans requires the plan sponsor (State) to conform with various requirements of the insurance contracts. Our services involved a review of the BC and NWNL contracts and a comparison of administrative requirements in these contracts to actual State administrative practices. The results of this review are presented below.

Blue Cross Contractual Requirements

The administrative requirements of the BC plan are stated in the Letter of Agreement signed October 16, 1981. The State has agreed, as described in the Letter of Agreement, to the following administrative conditions:

- The State shall collect the premium and transmit the appropriate premium payment to BC on or before the 15th of the month.

- The State shall keep records of self-pay employees, reimbursements and premium adjustments. The adjustments may be added to or deducted from the monthly premium payment to BC.

- The State shall provide BC with a list of employees with payroll deductions, employees who self-paid, employees who had premium adjustments and employees requiring reimbursements. In addition, a computer tape of employees eligible for benefits will be provided by the fifth of each month.

- The State shall provide and make available to BC such records and reports as may be reasonably necessary for the purpose of enrolling employees, processing terminations, effecting enrollment changes or for other purposes reasonably related to the administration of the agreement.

- The State agrees to establish necessary policies and procedures and make reasonable efforts to inform employees of their eligibility for coverage under this agreement. The State shall make available to the employees and submit the enrollment forms and materials for employees to BC.

- The State shall determine eligibility for coverage for each employee each month subject to the Conditions of Eligibility set forth in the benefits contract.

Based on our review, the State's administrative system and routines are capable of conforming to these conditions with the following exceptions:

- Computer tape of employees eligible for benefits. The State has agreed to provide a computer tape of eligible employees to BC by the fifth of each month. Based on our review, the State may experience difficulty in the following areas:

- Premium Reconciliation. The premium reconciliation takes approximately four and one-half days to complete. Depending on the payroll dates within the previous month and other administrative activities, the State may not be able to meet this deadline.

- Self-Pay Premiums. Agency Payroll Clerks, based on the Administration Manual, are to forward self-pay premiums to the State Personnel Division by the nineth of each month. As the checks and the self-pay transmittal are used to report self-pay participants, such participants cannot be reported to BC by the fifth of the month under the present system.

- Terminated Employees. Terminated employees may elect to terminate insurance coverage as of the end of the month in which employment terminates or the end of the following month. The combination of delays in reporting employment terminations plus the employee election of insurance termination date can (and based on our review, actually does) result in the State confirming coverage to BC and subsequently reporting termination of coverage with a request for refunded premium.

. Eligibility for coverage shall be determined each month. Based on our review, once an employee becomes a participant in the BC plan, the administrative procedures do not verify, on a monthly basis, that participants continue to meet the eligibility requirements. The payroll system does edit for employees working less than 20 hours per payroll period. We did not identify any system or routine to check if a previously ineligible employee may have had a status change to become eligible or to check if a participating employee has a status change (other than hours) to an ineligible class.

NWNL Contractual Requirements

The State's administrative requirements for the NWNL contract are not described in as direct a fashion as is the case with BC. Based on our review of the NWNL contract, the administrative requirements are:

. The State shall furnish NWNL such information as may be requested to properly administer the plan.

. The State shall provide to eligible employees appropriate information describing the plan and provide forms and assistance in the enrollment process.

. The State shall collect the premium and transmit the appropriate premium and premium transmittal form to NWNL prior to the expiration of the premium grace period each month (the grace period is a period of 31 days beginning on the first day of each month).

- The State shall establish appropriate administrative procedures to properly administer the plan, including periodic review of eligibilty.

- The State shall provide assistance to employees and beneficiaries as needed to properly file requests for benefits under the plan including conversions to individual policies following termination of employment.

Based on our review, the State's administrative system and routines are capable of conforming to the stated and implied requirements of the NWNL contract with the following exceptions:

- Premium Collection. The premium collection process results in the collection of incorrect premium amounts for employees who advance into a higher age premium bracket or who are entitled to a benefit increase resulting from a salary increase unless a manual change is made by the Payroll Clerk. Based on our review of actual practice, the number of such errors causes a premium imbalance and, as a result, incorrect premiums may be remitted.

- Eligibility Review. The present administrative practice does not include an eligiblity review (as discussed under BC, above).

- Employee Assistance. The EBB, based on our review, may not always be notified of disabled employees on self-pay status who are eligible to file for waiver of premium under the life insurance plan. As a result, EBB personnel may not be able to provide assistance in filing waiver of premium claims. The present administrative routine does not include a notification process to routinely advise terminated employees of a life insurance conversion benefit.

III - RESULTS: BLUE CROSS PLAN

Our review and audit of the BC claims adjudication process included interviews with BC management to determine the extent to which recommendations in our December, 1980 report had been implemented. A review of these recommendations and our comments regarding them appear in Section V.

Our services for the health care plan year ended July 31, 1981 involved a random reduction of health care claims processed during the period August 1, 1980 to July 31, 1981 plus interviews with BC personnel regarding the extent of claim processing changes made from the prior period. We also conducted interviews and performed a review of the procedures for processing dental claims. The results of our review and audit are presented below.

ELIGIBILITY VERIFICATION

All enrollment activity begins at the State agency or department level. Completed BC enrollment forms are sent to BC in Great Falls. The agency personnel/payroll office is responsible for completing a payroll status form to begin the payroll deduction and premium collection process.

BC reviews the enrollment card to be sure it is complete and verifies the effective date based on the date of employment and plan provisions. Once the effective date has been verified (and insurability is determined, if required) certain data from the enrollment card are entered into the membership records for use in verifying coverage when claims are received. Changes in coverage, such as adding dependent coverage, are processed in much the same manner.

The processing of this information is performed by BC underwriting and membership records personnel and not by claims processors responsible for adjudication of State employee claims.

The information regarding participating employees (stored in computer memory) is then used to verify an employee's eligibility under the plan during the claim payment process. Premium and coverage information is updated monthly from the data supplied by the State Department of Administration.

During our review and audit activity we identified three claims that had been improperly verified for eligibility. The results of the review of these two claims are presented below.

Termination of Insurance

Premium collection under the State's Payroll system results in the collection of employee contributions in advance. When an employee (insured for family coverage) terminates employment, he is given an option of receiving a refund of his advance contributions or remaining as a participant under the Plan for an additional month.

We reviewed two claims involving employees who requested and received a retroactive refund of contributions under this procedure. They had been reported to BC as covered by the Plan. The State subsequently requested a refund of premium. During the interviewing time, a claim was filed and paid.

Half Month Premium

The administrative procedures for the Plan prohibit the payment of less than a full month's premium for a participant. We reviewed a claim for a family member of a State employee involving the payment of only one-half month's premium.

CLAIM VERIFICATION

As part of the claim adjudication process, each claim is verified to make sure it represents charges for covered services and that the claim has not been processed previously.

During our review and audit we observed several claims that had been filed with less than sufficient identification information to permit proper claim verification. These claims are described below.

Incomplete Participant Data

A number of claims, primarily prescription drug receipts, had been filed with only the patient's name for identification. The BC claims department must attempt to identify the group number and certificate number (Social Security number) from their member records.

Incomplete Claim Data

BC claim filing instructions do not require the submission of a claim form. As a result, incomplete data are often received. (See Incomplete Participant Data, above) the Plan contains an exclusion for pre-existing conditions during the first six months of coverage. We noted four claims submitted for services that may have been excludable due to pre-existing conditions. Information regarding previous treatment for the condition was not supplied when the claim was filed and our review did not show documentation that BC requested such data prior to payment of the claim.

CLAIM PROCESSING METHOD

For the 1980-1981 plan year, BC used a manual claims processing method supported by computerized membership and claim history files. Under this system, the claim processor reviewed the claim documentation to make sure all pertinent data had been provided. Missing information could then be requested from the patient or provider of service.

The major steps in the claim process are described below. Additional information is also presented under STATISTICAL RESULTS, below.

Nature of Claim

The claim forms or statements will indicate whether or not the claim resulted from an accident (including work related accidents), a diagnosis, and a description of how the accident occurred or date the illness began. If this data is not provided in the doctor's claim form or statement, the missing information is requested. Prescription drug claims are not required to contain nature of claim information. Hospital statements may provide nature of claim information or such information may be obtained as a result of processing the doctor's claim.

Customary Charges

Hospital charges are not reviewed by BC to determine if charges are of a customary level. Most BC member hospitals participate annually in a BC rate review to establish acceptable charges.

Professional fees are reviewed for customary charges by referring to several published tables of relative values for specific procedures. Each procedure has been assigned a unit value by the organizations publishing the tables. The primary table is the Montana Relative Value Table (MRV).

The unit values for the MRV table are developed from a survey conducted by BC. If a procedure is not listed in the table, the Claims Manager or Medical Director will establish a reimbursement amount.

Coordination of Benefits (COB)

If the claim forms or statements indicate evidence of other insurance, the claim is routed to a COB specialist. The COB specialist will then decide to pay the claim or hold it and request further data.

If the State's plan is primary, the claim is paid without regard to other insurance coverage. If BC has not determined who is primary and it is the first claim for the family involving possible COB, the claim is paid if it is under $500 and a letter is sent to the patient requesting a return of any amounts received from other insurance. If the claim is over $500 or if it has been determined that the State's plan is secondary, no payment is made until information on other insurance is obtained.

COB data is requested annually from all BC participants. Information regarding other insurance is coded and entered into the computer membership record files to assist in identifying COB. Many participants elect not to respond to this request and as a result the data is incomplete.

Reasonableness of Service

Reasonableness of service is only reviewed on an indirect basis. Certain claims (based upon procedure, amount of charge, length of stay in the hospital and other factors) are reviewed to determine that the amount of payment is in compliance with the terms of the master contract and to establish the amount of payment.

Accuracy of Calculations

The claims processor re-adds each statement to verify that the total charges have been added correctly by the hospital and/or the doctor. Non-covered items are subtracted from the statement and the claim is paid at 90 percent or 100 percent based upon the master contact provisions. (As of August 1, 1981, the 90 percent co-insurance was reduced to 80 percent and a deductible was added.)

Cost Containment Activity

The major cost containment effort by BC is the review of claims for COB recovery and Third Party Liability. The master contract contains a subrogation provision allowing BC to recover if a third party is liable for losses sustained. A recent court ruling has, in BC's opinion, limited their ability to agressively enforce the subrogation clause.

Other cost containment activities were discussed under Cost Containment, above.

CLAIM TURNAROUND TIME

Claim turnaround time was measured from the date the claim documents were received at BC to the date the benefit check was mailed. While other measurement periods are used for turnaround time, PMM&Co. uses the "receipt to mail" period as it more closely approximates the period experienced by plan participants.

Our review of claim turnaround time covered 133 claims paid during the 1980-1981 plan year. Thirty-eight percent were paid within fourteen days of receipt of the claim documentation and the remaining 62 percent (83 claims) required more than two weeks processing time. Of these 83 claims, 52 had documented reasons for the delay. Thirty-one claims, 23 percent of the claims reviewed for turnaround time required more than two weeks to process and documentation of the causes of delay were not available.

Many claim documents, reviewed this year, had initially been filed without any indication of employer name or BC contract number. The process of identifying the proper contract and certificate (Social Security) numbers causes substantial delays for BC.

Additional information regarding claim turnaround time is presented as Exhibit A.

STATISTICAL RESULTS

This year our audit sample was selected on a random basis. The purpose of the random selection was to permit comparison of:

- Error data for BC and other claim processors and
- Error data for the State's plan in subsequent years.

The results of last year's audit and review are not appropriate for comparison to this years results. The sample last year was selected on a judgemental basis as agreed to by the State.

The sample this year was selected on a "Monte Carlo" basis. The sample included 200 medical claims processed by BC during the twelve months ended July 31, 1981. The total dollars of paid claims in this sample was $19,368.09 and the average payment in the sample was $96.84.

Error Frequency

We identified twelve claims, of the 200 in our sample, with errors resulting in incorrect payments. This represents a 6 percent error frequency in the sample.

The most common payment errors involved payment for services not covered by the State's plan. Six claims involving noncovered services were paid by BC. Other payment errors observed include:

- Improper review of Coordination of Benefits (COB),
- Improper review provider statements, and
- Inaccurate calculation of benefit amounts.

We also identified seven additional claims involving incomplete adjudication and other improper processing events. While these claims did not result in identified payment errors, payment errors could have resulted due to incomplete adjudication or improper processing. Each of the 19 processing errors is summarized in Exhibit B.

Payment Error

Eleven of the 12 claims with payment errors involved overpayments. These overpayments totaled $261.66. The one underpayment of $8.61 was observed. The overpayments, net of underpayments, were $253.05 or 1.3 percent of the $19,368.09 claim payments in the sample.

Comparison of Error Rates

While we are unable to compare the results in this year's report to the results in last year's, we have compared this year's results to error rates generally available in the industry and error rates observed in other claim systems with which we are familiar.

Based upon error information provided to us by several insurance and Blue Cross/Blue Shield claim departments, error frequencies generally range from 4 percent to 6 percent and net payment errors generally range from 1/2 percent to 3/4 percent. The results of PMM&Co. audits and reviews conducted under similar conditions produce error rates somewhat higher than those reported by claim departments. The results of our work indicates error frequencies among claim departments generally range from 5 percent to 7 percent and net payment errors generally range from .6 percent to 1.0 percent.

BC processed claims during the year ended July 31, 1981 on a primarily manual claim payment system. Since August 1, 1981, a new computerized system has been in use. We have been advised by BC that errors resulting from payment for noncovered services and charges in excess of usual, reasonable and customary fee limits should not occur under the computerized system.

DENTAL CLAIM SYSTEM

The BC claim system for dental claims is a computerized system. Based on our interview process, we believe BC has proper procedures and methods to determine eligibility and adjudicate claims for State employees. We did not test any claims paid under the system, nor did we conduct any review activities related to the computer program other than described below.

Processing Method and Internal Control

Claims are date stamped and sorted when received. Processors prepare code sheets and group claims into batches of 25 items.

The data are then keyed into CRT's. Eligibility is verified against the membership file. The claim is verified initially by the processor and again through a series of computer edits based on data in the claim history file.

Once these steps have occurred, the claim is paid by the computer based upon plan provisions.

As is the case in the medical plan, appropriate separation of duties and other internal control procedures are practiced, based on our review.

Plan Provision Programming

We reviewed the dental plan provisions with the BC personnel responsible for programming the plan provisions for computerized processing. Based on our review, the following comments were made to BC:

- Flouride treatments are only covered by the Plan up to age 19. We suggested this provision be programmed so as to avoid the need to manually check the patient's age prior to data entry.

- Full mouth X-rays are limited to one such X-ray each three years and bitewings are limited to one set each six months. We suggested the computer program include a date edit for X-rays so as to avoid payment for more frequent service.

- The Plan pays 50 percent of the cost of space maintainers. We suggested a programming change to correct the presently programmed payment of 100 percent of such services.

- Crowns are covered by the Plan, but payment is limited to the allowable charge for amalgam restoration. We suggested a change to the present program which treats crowns as a noncovered service.

- The Plan excludes certain splinting and occlusion restoration services. Under the present BC system, such services would be paid at 50 percent. We suggested the BC program be modified to agree with the Plan's provisions.

- The BC system does not cover treatment for fractures or dislocations. Under the State's Plan, such service is reimbursed at 50 percent unless payment is made under the accident provisions of the health care plan. We suggested the medical and dental claims systems be coordinated so as not to reject a claim submitted under the wrong plan.

IV - CONCLUSIONS AND RECOMMENDATIONS: STATE ADMINISTRATION

Our conclusions and recommendations regarding the Administrative Manual, actual administrative practice, and conformance of administrative practice to insurance contract provisions are presented below.

WRITTEN ADMINISTRATIVE INSTRUCTIONS

We conclude the present Administration Manual for the insured employee benefit plans does not provide sufficient instructions to assist the Agency Payroll Clerks in the proper administration of the plans. We further conclude that written instructions for the EBB administrative activity would be of value to the EBB in providing consistent plan administration.

Presented below are our recommendations regarding improvements in the written administrative instructions.

Agency Administration

We recommend the Manual for Agency Payroll Clerks be prepared as a step-by-step "how to" Manual and that the Manual be divided into sections describing each administrative activity. For example, the section describing the process of enrolling a new employee should include:

- The process of identifying a new employee, including who is to notify the Payroll Clerk and how eligibility is determined.
- Action to be taken to provide the new employee with material describing the plans and appropriate enrollment forms as well as when and to whom the forms are to be returned.
- The process of completing appropriate payroll deduction forms (including the need for and instructions for one time deductions and the determination of coverage effective dates) and the distribution of completed forms.
- Sample forms showing items to be completed by the employee and the Payroll Clerk.

We further recommend the Manual be updated as refinements and improvements in the administrative process occur.

Department of Administration Activity

The majority of the Department's activity is performed or coordinated in the EBB. We recommend the administrative procedures be described in manual form similar to the Administration Manual for Payroll Clerks. The preparation of written instructions for EBB activity should help insure uniform plan administration and provide for an orderly transfer of duties in the event of employee turnover or promotion of present personnel.

PLAN ADMINISTRATION

Our conclusions and recommendations regarding the actual administrative activity compared to written instructions are presented below.

Agency Administration

We conclude that agency Payroll Clerks generally have a good understanding of the administrative procedures and administer the plans in conformance with the Manual.

We make the following recommendations to improve the degree of conformance of agency administration to the Manual:

- EBB should expand the Payroll Clerk training program to include additional Clerk training for an agency or department in areas where administrative difficulties exist.

- The Department of Administration (D of A) should request assistance, as needed, from agency personnel to insure the proper flow of information (on a timely basis) to Payroll Clerks for proper plan administration.

- The D of A should request modifications to the present payroll system to improve administration as follows:

  - The one time deduction for new employees plus the regular biweekly deduction authorization should be reported at the same time and perhaps on the same report.

  - Life insurance amount increases due to salary changes and premium changes due to age or salary changes should be made automatically based on salary and birth-date data presently in the payroll system.

- The D of A should review the procedures regarding self-payment of premium and the option for terminated employees to continue coverage beyond the end of the month following employment termination. Delays in self-payment of premium and retroactive requests for premium refunds for terminated employees add to the complexity of administration for Payroll Clerks and EBB personnel.

EBB Administration

Administrative activities by EBB personnel and other personnel in the D of A appears to be effective. The recommendations presented below are designed to reduce the time required to administer the plans and/or improve the internal routine.

- Premium Statement Preparation. Based on our review, we believe the premium statement preparation will be improved if the Payroll Clerk Manual is revised and other agency administration recommendations described above are implemented.

- Waiver of Premium. Employees on self-pay status should be reviewed at the time they request self-pay to determine if self-pay is requested for medical reasons. Those who request self-pay for medical reasons should be reviewed again after six months to determine if a waiver of premium claim for life insurance should be filed.

- Premium Refund Activity. The premium refund activity involves the preparation of a worksheet and typewritten lists for Central Services and BC. We recommend the preparation of the lists be discontinued and photocopies of the worksheets be used to support refund requests.

  We further recommend the refund checks issued to employees be delivered to the Payroll clerks or mailed to employees by Central Services rather than returning them to EBB for distribution.

- Collection of Self-Pay Premium. This activity required approximately four and one-half days to complete prior to our review. Ms. Loughrie performed a number of manual activities. We recommend the self-pay premium collection and reconciliation process be performed using a CRT with a basic storage and totaling program to eliminate the volume of entries presently required. Based on our analysis, we believe the simplification of this process (if our recommendation is implemented) may reduce the monthly administrative time by 24 to 32 hours.

Other Recommended Administrative Changes

During our review, we observed several activities which we believe could be improved. Each such activity and recommendations are presented below.

- Inter-department Transfers. Based on our review, difficulty may occur when an employee is transferred between departments. We suggest a standard transfer form be used to transmit data (including insurance data) so as to reduce the possibility of records error resulting from transfer.

- Termination Information. Confusion appears to exist among employees regarding their rights and options under the plans at termination of employment. We suggest the preparation of a standardized information packet explaining the optional continuation of coverage and the conversion options. The packet should also contain appropriate forms.

. Leave of Absence. Payroll Clerks are not always advised when employees take a leave of absence without pay. As a result, coverage may be terminated for an employee who may have desired to self-pay the premium. We suggest Payroll Clerks be instructed to review the status of employees who do not complete a time sheet for a payroll period. A form letter may then be mailed to the employee explaining the self-pay system. This process should disclose employees on leave of absence and help eliminate inappropriate coverage terminations.

ADMINISTRATIVE COMPLIANCE WITH INSURANCE CONTRACTS

As indicated above, we conclude the State's administrative system and routine are capable of conforming to the majority of the insurance contract requirements. The recommendations presented below are designed to improve the compliance.

Blue Cross Plan

The recommendations regarding improved compliance with the BC contract are:

. Computer Tape Listing. The BC contract requires the State to submit a computer tape listing of participants to BC by the fifth of each month. As this listing is used to verify coverage for claim payments, it must be accurate. To avoid delays and inaccurate information, we recommend:

- Self-pay premiums be collected by Payroll Clerks and delivered to EBB by the first of each month rather than the nineth.

- Terminated employees should not be permitted to request refunds of premium after the first of the month for which the premium is due.

. Eligibility Verification. We recommend Payroll Clerks review the pre-payroll listings monthly to verify the continued eligibility of employees contributing to the plans and to identify employees whose status may have changed and are now eligible to participate in the plans. (This recommendation also applies to NWNL's requirements.)

NWNL Plan

The recommendations regarding improved compliance with the NWNL contract are:

- Premium Collection. Under the present payroll system, premium collection and reconciliation is difficult due to computer program limitations. To comply with contractual requirements, we recommend the computer program be modified to make coverage and premium changes resulting from age and/or salary changes. This modification (along with other suggestions above regarding reporting of events) should reduce the volume of coverage and premium errors and improve the premium collection and reconciliation process.

- Waiver of Premium. We further recommend initial requests for self-pay status be reviewed for possible disability status and those still disabled after six months should be identified for eligibility for waiver of premium claim filing.

V - CONCLUSIONS AND RECOMMENDATIONS: BLUE CROSS

Our conclusions and recommendations regarding the medical plan and the dental plan are presented below.

MEDICAL PLAN

Based on our review and audit of the medical plan, we conclude that the frequency of payment error is similar to the frequency of payment errors observed by PMM&Co. in similar reviews and audits of other claim processing systems. We further conclude that the net overpayments are in excess of the net over payments observed in similar reviews and audits. Specific conclusions and recommendations regarding the payment errors and other areas of review are presented below.

Error Rate

The net overpayment error rate was 1.3 percent of claim payments audited. As discussed in Section III, this is .7 to .3 percentage points above the range of net payment errors generally observed by PMM&Co. in similar engagements.

Approximately half of the net overpayments were the result of payment for noncovered services. These errors totaled $128.57 of the $253.05 net overpayments identified. We have been advised by BC that payment for noncovered services and payments in excess of customary fee limits will be reduced, if not eliminated, under the new computerized claim system.

We recommend the State conduct a statistical review and audit next year of medical claims under the same conditions as existed this year to evaluate the effectiveness of the computerized claim system in use by BC. As the Plan will be converted to a minimum premium plan as of February 1, 1982, it may be appropriate to evaluate the system's effectiveness prior to the completion of the 1981-1982 plan year.

Claim Turnaround Time

Based on our claim review experience with other claim systems generally 60 percent of the claims reviewed for turnaround time will have been paid in two weeks or less. Only 38 percent of the medical claims so reviewed were paid within two weeks. Sixty-two percent required longer processing time. However, many of these claims had justifiable reasons for delay.

We recommend BC and the State take the following action regarding turnaround time:

- Prepare and distribute to employees a set of instructions regarding claim filing to include specific requirements for including the employee's Social Security number and the Plan's contract number on each receipt or bill.

- Agree on a turnaround time goal such as 85 percent of claims paid within two weeks of receipt (or proper documentation for delay.)

- Establish a monitoring and information feedback system to determine the degree of improvement in turnaround time.

Eligibility Verification

BC performs an appropriate verification process. Based on our review, we conclude that BC will refund premium for terminated employees for whom a refund request is made even if such request is after the first of the month for which coverage applies.

We have suggested modification of the provision for terminated employee coverage (See Section IV). We recommend the State and BC agree to refund no more than the requested premium less claims paid during the period for which a refund is requested if the State does not agree to discontinue the practice of retroactive premium refunds.

We further recommend BC remind their membership department staff not to accept less than a full month's premium for employees.

Prior Year's Report

As indicated above in Section III, Many of our recommendations regarding the BC medical plan presented in our report dated December, 1980 have not been fully implemented. We recommend the State and BC jointly review those recommendations and work toward implementation as deemed appropriate.

DENTAL PLAN

Our services regarding the dental plan involved a review of the system developed to process dental claims. As BC began processing dental claims as of August 1, 1981 and very few claims had been processed prior to our audit and review, our services were not designed to include an audit of processing accuracy as indicated above. We did not conduct review activities related to the BC computer program other than those described in Section III.

Based on our review, we conclude that BC should have an effective system for processing State employee's dental claims once the programming changes discussed in Section III have been made. We have been advised by BC that they have made these changes.

We recommend the State audit dental claims processed during the first six months of the current plan year to verify that the programming changes are effective and that the system is performing properly.

MEDICARE PART B

We observed that the present BC plan permits employees who are over age 65 to elect not to pay the Medicare Part B premium and receive Part B type claim payments as if they were under age 65. This practice may result in such employees experiencing a delay in the effective date of Part B coverage following termination of employment.

We recommend the State pay the Medicare Part B premium for employees over age 65 as part of the employer contribution to employee's health care benefits and request a corresponding reduction in premium for such employees from BC.

COMMENTS ABOUT DECEMBER 1980 RECOMMENDATIONS

The recommendations made in our December, 1980 report regarding the BC Health Care Plan and the action taken on these recommendations are presented below.

Eligibility Verification

BC verifies the eligibility of claimants based upon Social Security numbers and paid premium reports supplied by the State. Paid claim information including the employee's Social Security number and date of service is retained by BC. PMM&Co. recommended that BC make this information available to the State. The State could then perform an eligibility verification audit based on records of employee participation.

We understand BC has informed the State that this information is available for their use. However, we further understand the State has not implemented an eligibility verificaiton audit process.

Coordination of Beneifts (COB)

BC currently requests information regarding other insurance coverage (COB information) at the time an employee enrolls under the Plan and at least annually thereafter. If current COB information is not on file, BC will pay a claim under $500 without first obtaining the current information.

We recommended that this pay and request process be discontinued for claims over $100 and that BC work to gain the cooperation of the State, doctors and hospitals in obtaining COB information. Our review results indicate that no changes in the gathering of COB information or processing of claims involving the possibility of other insurance liability have been made.

Duplicate Payments

We recommended that BC claim processors be more careful in their review of paid claim history for possible duplicate claims and that providers be encouraged not to refile statements previously submitted.

The present BC claim system, implemented in 1981, contains several computer edits designed to identify duplicate claims. If effective, the payment of duplicate claims should be avoided.

Concurrent Review

We further recommended the State and BC agree to engage the Montana Foundation for Medical Care or a similar organization to conduct medical reviews for the Plan. We understand this is currently under consideration by the State.

Contract Provisions

The BC contract contains certain provisions regarding the use of LPN's and treatment of obesity. BC has administered the Plan based on administrative procedures that do not agree with these provisions. We recommended BC and the State agree to the variances.

The contractual provision regarding obesity has been rewritten. No agreement has been made regarding LPN's.

Claim Documentation

Claim processors do not consistently document action taken regarding claim processing. We recommended that processors be more consistent regarding documentation.

No material increase in documentation was noted in our claim sample this year as compared to last year.

Cost Containment

Actual paid claims during the first plan year exceeded the claim level expected by BC. Our report recommended BC and the State discuss the use of cost containment features as a method of reducing plan costs.

The following action has been taken to control plan costs:

- The administration of the provision regarding reasonable and customary professional fees has been amended to adhere to specific maximum fees per procedure based on annually determined levels of usual, reasonable and customary fees.

- The review of accident claims has been improved to include a more complete evaluation of the existence of an external event causing the accident.

- The approval process for air ambulance has been improved to include a review of local medical services and the appropriateness of non-air ambulance services.

- The Plan's benefits have been amended to add a deductible and reduce the co-insurance to 80 percent from 90 percent.

Premium Allocation

Our review of claim experience during the 1979-1980 plan year indicated that the premium rate for employee coverage exceeded the premium level needed to support the employee claims and the dependent premium rate was below the needed premium level. (In total, paid claims exceeded premium.) We suggested the State review the premium imbalance.

We have been advised that the State intended the premium imbalance and no adjustment was made.

Exhibit A

STATE OF MONTANA

Blue Cross of Montana
Claim Turnaround Time

Elapsed Time	Number of Claims	Percent of Total
0 - 7 Days	15	11.3%
8 - 14 Days	35	26.3
15 and Over Days - Documented	52	39.1
Subtotal	102	76.7
15 and Over Days - No Documentation	31	23.3
Total	133	100.0%

STATE OF MONTANA

Blue Cross of Montana
Claims Adjudication Errors

Description	Error
Premium initially paid through 10/30/80. State then requested termination and refund of premium as of 8/30/80. Also, one similar claim was noted during review.	BC paid claim with service date of 9/8/80 prior to refund request by State. This is not an adjudication error, but an indication of a need for revised refund procedures.
Claim for services on 11/4/80 for individual with effective date of 6/1/80. Claim was paid for services not covered by the Plan.	Overpayment of $18.54. Also, claim may have involved pre-existing condition. No evidence of BC review for pre-existing condition.
Claim for services two months after coverage effective date. Possible pre-existing condition.	No evidence of review for pre-existing condition by BC.
COB data received six months following claim payment date. File does not show if COB data were also available at date of claim payment.	Overpayment of $1.40. While this is a minor error, proper maintenance of COB data may have avoided the error.
Claimant is over age 65, but did not apply for Medicare Part B coverage. Claim paid as if under 65 for professional services.	No payment error, however, State may wish to re-evaluate the Part B option for employees over age 65.
Claim involved possible non-covered service.	BC did not perform review to determine that service was covered based on circumstances of service.
Claim involved services that may have been performed as a result of an accident. Claim form did not indicate a diagnosis.	BC review of claim did not include a request for diagnosis. Claim was paid as an illness claim.
Claim for services was calculated incorrectly.	Minor error, overpaid by 81 cents, caused by processor calculation error.

STATE OF MONTANA

Blue Cross of Montana
Claims Adjudication Errors

Description	Error
BC accepted one-half month premium. No claim paid.	No claim processing error. Agreement with State is not to accept one-half month premium. State is also not to pay one-half month premium.
Claim for new born care paid by BC. This is not a covered expense under the Plan.	Overpayment of $55.67 due to failure to process based on Plan provisions.
Claim for services within two months of effective date involved pre-existing condition.	Overpayment of $54.25 due to failure to identify pre-existing condition as defined in contract.
Claim for services performed on 20-year old child of employee. Claim form indicated patient was employed.	BC did not verify dependent status or possible COB with child's employer.
Patient received services within three months of effective date for pre-existing condition. Patient had previously been insured by BC through prior employer.	Claim was paid properly. However, the payment resulted in an overpayment of $22.54 as pre-existing condition claims are not eligible expenses under the State's Plan.
Claim for $4.00 was paid as if it were a charge of $14.00.	$9.00 overpayment resulted from improper reading of provider's bill.
Claim for $26.00 was paid as if it were a charge for $36.00.	$9.00 overpayment resulted from improper reading of provider's bill.
Claim included $10.00 charge for non-covered services.	Overpayment of $9.00.
Claim for noncovered well baby services.	Overpayment of $63.90.

STATE OF MONTANA

Blue Cross of Montana
Claims Adjudication Errors

Description	Error
Claim for assistant surgeon was reduced due to improper calculation of reasonable and customary allowance.	Underpayment of $8.61 due to improper calculation of allowable fee.
Claim documents show statements for $10.45. Claim paid as if $29.95. No documents for the remaining $19.50. Subsequent claim for another family member for $19.50 with same date of service was also paid.	Overpayment of $17.55 (90% of $19.50) due to duplicate payment of claim.
Claim history on computer has been doubled for some employees.	No error yet identified. May result in overpayments due to incorrect history.

Exhibit C

Blue Cross®
of Montana

P. O. Box 5004
3360 10 Avenue South
Great Falls, Montana 59403
Phone: 761-7310

January 22, 1982

Mr. Ray Wolcott, Jr.
Peat, Marwick, Mitchell & Company
P. O. Box 13127
Kansas City, Missouri 64199

Dear Mr. Wolcott:

The following represents the response by Blue Cross of Montana to the draft report of the audit performed on the State of Montana employee health and dental benefit plan.

The Plan is not disputing the findings of the auditor but, as has been stated in the body of the report, during the period of time that the audit pertains to, the Plan used a manual claims processing system supported by a computerized membership and claims history file. It should be noted that in September of 1981, a completely automated claims processing system was implemented and will address most of the problem areas found during the audit.

Eligibility Verification - Under the new system, once a claim is entered into the system, it can be processed only with the information that is in the membership file. If we do not have a current eligibility date, the claim cannot be processed. A procedure has now been set up that requires claims history to be reviewed before a refund of dues can be made with an appropriate offset of funds for the amount of claims paid relating to the period of refund.

Further, the Plan now accepts only full months' membership dues.

Claim Verification - The automated system requires that sufficient information be entered into the system before that claim can be adjudicated. Claims without all required data will be automatically pended and not processed until that data is received from the appropriate party.

The Plan is in the process of developing written guidelines for its subscribers in how to file a claim. Instructions will be given that informs claimants of the exact information needed for a claim to be processed without delays.

The Plan has set up a sub-department that reviews all applicable claims for preexisting conditions. All claims that are incurred during the first 365 days of enrollment are automatically pended and reviewed by our medical personnel for preexisting conditions.

Claim Processing Method - As noted above, our methods are now changed from a manual system to an automated system.

The basic information required to process a claim will pertain to all claims. A requirement to supply nature of claim for prescription drugs will be given to the State employees in our transmittal on "how to file a claim".

Blue Cross of Montana, as Fiscal Intermediary for the Medicare program, does have a permanent position on the Hospital Rate Review Board and, therefore, feels that a review of all hospital charges is accomplished annually.

The findings in the area of Coordination of Benefits are the same as the preceding year. The Plan is of the opinion that our present policy of paying one claim for $500.00 or less adequately protects the group. We are taking the finding and recommendation under advisement and developing the statistics to support our position.

Statistical Results - With the implementation of the automated system, sufficient additional edits have been installed for us to experience an error rate that will be within the ranges that are generally found within the industry. Additionally, the preexisting screen explained above will further reduce our error rate.

Conclusions and Recommendations - We appreciate the findings of the auditors and the subsequent recommendations made. Virtually all recommendations made have been implemented prior to the time of this report, both from the current period as well as those recommendations made in the 1980 report.

It is the intent of Blue Cross of Montana to work with the State of Montana to strengthen the administration of the health and dental plan for our mutual benefit.

We thank you for the opportunity to comment on this audit report.

Sincerely,

Carl J. Tanberg
Vice President, Provider Service
Blue Cross of Montana

CJT:wph

Exhibit D

DEPARTMENT OF ADMINISTRATION
DIRECTOR'S OFFICE

TED SCHWINDEN, GOVERNOR
MITCHELL BUILDING

STATE OF MONTANA

(406) 449-2032
HELENA, MONTANA 59620

January 25, 1982

Ray Wolcott, Jr.
Peat, Marwick, Mitchell, & Co.
P. O. Box 13127
Kansas City, MO 64199

Dear Mr. Wolcott:

I have reviewed your draft of the review and audit of the State Employee Group Benefit Plan. The following comments pertain to Chapter IV - Conclusions and Recommendations: State Administration.

Written Administrative Instruction

A new Administration Manual was written in November, 1981. The manual is divided into chapters that explain in "how-to" terms, enrollment, termination, transfer, and premium payment procedures, as well as claim filing and identification of eligible employees. The manual also contains sample forms for each procedure that may take place in the administration of the insurance program.

A manual for administrative activities that take place in the Employee Benefits Bureau is in the process of being written, and should be complete by February 15.

Plan Administration

- During the week of December 7 to 11, 1981, training sessions were held for payroll clerks of all State agencies. The new Administrative Manuals were distributed and each section was read and discussed. The success of that training was indicated in the improved self-pay and refund reports which came in the following month. The Employee Benefits Bureau will continue to monitor the agency administration, and will respond where difficulties seem to exist by on-site training if that can be arranged.

- The Department of Administration will request assistance from agency personnel to insure the proper flow of information on a timely basis to payroll clerks, so that they will be aware of leaves-of-absence, terminations, and any changes in employee status that affect insurance administration.

.The Department of Administration cannot comply with the suggestion to have premium adjustments for life insurance made automatically by the payroll system. However, a change in the program that edits premium deductions will allow us to determine the correct deductions and then remit the proper amount to the carrier each month.

.One-time deductions can be reported at the same time the regular bi-monthly deductions are reported. This is described in the new Administration Manual.

.The Department of Administration will continue to allow terminating employees to have the option of continuing coverage until the month following termination, but will not allow refunds for that month's coverage after the first of the month.

EBB Administration

.Premium statement preparation has been improved with the use of the new Administration Manual.

.The EBB will monitor PERD reports to determine those retirements that were for disability, as these reports contain a code that indicates the reason for retirement. Persons whose code indicates disability retirement will be contacted for waiver of premium information. Payroll clerks will continue to monitor self-pays for disability retirements.

.A new procedure is being used for refund activity. This involves the preparation of a master list which is copied three times for the Auditor's office to use in preparation of warrants, and one copy for Blue Cross's use.

Refund checks are now mailed directly from the Auditor's office to the employee.

.Self-pay premium information is now loaded directly into the computer terminal from the transmittal sheets turned in by payroll clerks. This has saved approximately three days work.

Other Recommended Adminsitrative Changes

.Interdepartment transfers are addressed in the new Administration Manual. In the training session, the importance of letting Blue Cross know that the employee has a new group number was also stressed.

.Employees are advised of their termination rights in the Employee Benefit Plan handbook, a new copy of which was given to each employee in December. Rather than develop a standardized information packet explaining termination options, the EBB recommended that each agency develop its own packet. This recommendation was made to payroll clerks in the training sessions held December 7 - 11.

.Payroll clerks have been advised to use pre-payroll information to determine which employees are not in pay status during a pay period, and to contact these employees regarding self-pay procedures. They have also been instructed to review the deduction reports that come from Central Payroll approximately five days after the second pay period in order to see whether any employee did not have full deductions made. These two procedures should alert payroll clerks to contact the employees in time to collect the money and report the self-payment by the 9th of the month for which payment is to be made.

Administrative Compliance with Insurance Contracts

Blue Cross Plan

.The State sends to Blue Cross by the 5th of each month, a computer tape that lists all deductions made through Central Payroll. A paper copy of the deductions is also furnished to Blue Cross as well as to each agency. Because the payroll clerks review this paper and make corrections (such as additional payment if only half the month's premium was deducted) on the self-pay transmittal, it would not be possible for self-pay premiums to be delivered to the EBB by the first of each month rather than the ninth.

.Terminated employees will not be permitted to request refunds of premium after the first of the month for which the premium is due.

.Payroll clerks have been instructed to review pre-payroll listings to verify eligibility of employees to participate in the plans, and also to determine when they are entitled to the State contribution. In addition, the EBB will monitor self-pays so that periodic checks can be made to verify that employees who are on leave and receiving Workers' Compensation are still eligible, and that employees who are on leave-without-pay remain on the plan for only one year.

NWNL Plan

.The computer programs that produce the summary gate for Northwestern National Life Insurance premiums are being rewritten. While it will not be possible to make adjustments to deductions automatic, the new program will identify the invalid premiums and indicate what the correct deduction would have been. This program will make it possible for the State to pay the correct premium and provide the correct volume of coverage information to the NWNL.

.Information about the waiver of premium eligibility will be furnished to each employee who retires because of disability as discussed in the section on EBB Administration.

In summary, the recommendations made in your audit have been implemented where it is possible at this time to do so.

Sincerely,

Morris Brusett

Morris Brusett, Director
Department of Administration

MB/pb